No. 92-893

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1992

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY and CONSOLIDATED GROUP, INC.,

Petitioners,

v.

RICHARD FUGARINO, JO MARIE FUGARINO, and MARC A. FUGARINO,

Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

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PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether employers covered under the same ERISA plan as their employees are "participants" or "beneficiaries" in that plan, and are therefore precluded by ERISA's exclusive federal scheme from asserting state law claims for benefits under that plan.

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Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

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PETITION FOR WRIT OF CERTIORARI

Hartford Life and Accident Insurance Company ("Hartford") and Consolidated Group, Inc. ("Consolidated Group")* respectfully petition this Court for a

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* All parties to the proceeding below are listed in the caption to this petition. Hartford Life and Accident Insurance Co. is wholly owned by Hartford Accident and Indemnity Co. Its only partially-owned subsidiary is International Corporate Marketing Group, Inc. Consolidated Group, Inc., has no parent companies or subsidiaries (other than wholly-owned subsidiaries) to be disclosed under Sup. Ct. R. 29.1.

writ of certiorari to review the judgment of the United States Court of Appeals for the Sixth Circuit in this case.

The Sixth Circuit's decision holds that employers (sole proprietors, partners, and corporate owners) covered in the same ERISA plans as their employees are not "participants" or "beneficiaries" entitled to seek plan benefits under ERISA, and yet are entitled to seek inconsistent remedies under state law for the same plan benefits. This decision is based upon a fundamental misunderstanding of ERISA and the policies of Congress that underlie it, is at odds with the holdings of other circuits, and will create confusion, uncertainty, and unnecessary litigation in the administration of ERISA plans.

OPINIONS AND ORDERS BELOW

The opinion of the Court of Appeals, filed July 8, 1992, is reported at 969 F.2d 178 and is reproduced in Appendix ("App.") A at 1a-15a. The order of the Court of Appeals denying rehearing en banc, filed August 24, 1992, is unreported and is reproduced in App. B at 16a-17a. The opinion of the District Court, filed June 4, 1991, is unreported and is reproduced in App. C at 18a-25a.

JURISDICTION

This action was originally filed in the Court of Common Pleas of Summit County, Ohio, and was removed to the United States District Court for the Northern District of Ohio pursuant to 28 U.S.C. § 1441. The District Court had jurisdiction over this action under 28 U.S.C. § 1331 and section 502(e)(1) of the Employee Retirement Income Security Act of 1974 ("ER-

ISA"), 29 U.S.C. § 1132(e)(1). The jurisdiction of the Court of Appeals was based on 28 U.S.C. § 1291. The Court of Appeals denied rehearing en banc by order dated August 24, 1992, and this Petition is being filed within the 90-day period following entry of that order provided by Sup. Ct. R. 13.1, 13.3, as extended by Sup. Ct. R. 30.1. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTE INVOLVED

This case involves sections 3(6)-(8) and 514(a) of ERISA, 29 U.S.C. §§ 1002(6)-(8), 1144(a), which are set out verbatim in App. D at 26a.

STATEMENT OF THE CASE

A. Statement of Facts

This case involves state law compensatory and punitive damage claims under an ERISA-covered health plan provided by The Glens Restaurant to Richard Fugarino, the sole proprietor of the restaurant, his employees, and their respective dependents. Hartford issued a health insurance policy to a multiple employer trust administered by Consolidated Group in which the restaurant participated, resulting in coverage for the employer and his employees. App. A at 1a-2a; App. C at 18a-19a, 23a-24a.

In 1988, a severe automobile accident left Richard Fugarino's son, Marc Fugarino, a paraplegic. Subsequently, a dispute arose in processing claims for medical expenses relating to the accident. In February 1989, an action was filed in state court seeking compensatory and punitive damages for alleged bad faith in handling both the Fugarino claims and various

other restaurant employee claims. App. A at 2a; App. C at 19a.[1]

B. Decisions of the Courts Below

On March 20, 1989, the case was removed to federal court pursuant to 28 U.S.C. § 1441. App. A at 4a. Hartford filed a motion to dismiss asserting, among other things, that the plaintiffs' claims were preempted by ERISA. *Id.* On June 4, 1991, the United States District Court for the Northern District of Ohio granted Hartford's motion to dismiss. Relying on this Court's decision in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), the District Court held that (1) the health insurance plan was an "employee welfare benefit plan" governed by ERISA, App. C at 22a-23a, and (2) the plaintiffs were "participants" and "beneficiaries" of the plan within the meaning of ERISA whose state law claims were preempted. App. C at 25a.

On appeal, the United States Court of Appeals for the Sixth Circuit agreed that the plaintiffs' coverage was a "plan, fund, or program . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, or hospital care or benefits . . . ." App. A at 7a-9a (quoting ERISA § 3(3), 29 U.S.C. § 1002(3)). However, despite finding that Fugarino's medical coverage was an ERISA plan, and despite the uncontroverted evidence that Fugarino participated in and received benefits from that ERISA plan,

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[1] Claims concerning medical bills for Marc Fugarino and the restaurant employees were settled and dismissed. App. A at 3a; App. C at 19a.

the Court of Appeals held that the Fugarinos were not "participants" or "beneficiaries" under ERISA and that their benefit claims were not governed by ERISA. App. A at 12a-13a.

The court reached the latter conclusion by focusing on a Department of Labor regulation stating that plans covering employers *only* are not ERISA-governed "employee benefit plans." App. A at 12a (citing 29 C.F.R. § 2510.3-3(b)).[2] This regulation adds that an individual who wholly owns a trade or business (incorporated or unincorporated) is not considered an "employee" with respect to that trade or business. *Id.* (citing 29 C.F.R. § 2510.3-3(c)(1)). Although the regulation states that it defines "employee" only "[f]or purposes of this section" (i.e., for purposes of determining if an employee benefit plan subject to ERISA has been created), the court below applied that definition out of its explicit context to limit the meaning of "participant" and "beneficiary" in unrelated sections of ERISA, which use the term "employee" in describing those individuals entitled to pursue remedies under all of Title I of ERISA. ERISA § 3(7)-(8), 29 U.S.C. § 1002(7)-(8).

Applying this reasoning, the court below held that an individual who is not an "employee" within the narrow meaning of the regulation cannot be a "participant" or "beneficiary" with standing to pursue ERISA benefit actions. App. A at 12a-13a; *see* ERISA § 502(a), 29 U.S.C. § 1132(a) (ERISA standing pro-

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[2] This regulation, of course, is not directly applicable in this case because the plan sponsored and administered by the restaurant did cover common law employees of the restaurant as well as the restaurant's owner. *See supra* p. 3.

vision); ERISA § 3(7)-(8), 29 U.S.C. § 1002(7)-(8) (definitions of "participant" and "beneficiary" under ERISA). Thus, because Richard Fugarino was a sole proprietor, the court held that he and his dependents could not be "participants" or "beneficiaries" entitled to pursue a benefit remedy under ERISA. App. A at 13a.

Since the Fugarinos had no standing to seek ERISA remedies for ERISA plan benefits, the court concluded that they must be free to pursue non-ERISA remedies available under state tort laws governing insurance contracts. *Id.* At the same time, other employees of the restaurant, who were clearly "participants" under ERISA, were preempted from pursuing non-ERISA remedies. *Id.*

REASONS FOR GRANTING THE WRIT

This case involves an issue at the very heart of ERISA's regulatory purpose: the fulfillment of plan benefit promises. In reviewing the claims for ERISA plan benefits in this case, the court below correctly recognized that the plan was an "employee benefit plan" subject to ERISA. Moreover, the court allowed the plaintiffs to obtain benefits from a plan in which it held the plaintiffs were not "participants" or "beneficiaries." However, the court held that the plaintiffs could not sue for these benefits under ERISA, but it allowed them to pursue non-ERISA state law claims for those ERISA benefits. In effect, the court bifurcated a single plan into an employee benefit plan governed by ERISA, and an insurance contract governed by state law.

The court's decision reflects a fundamental misunderstanding of ERISA, and conflicts with decisions

of this Court and other state and federal courts. In passing ERISA, Congress made clear that all employee benefit plans are subject to *exclusive federal regulation*. Thus, once a plan comes under ERISA's regulatory umbrella, as in this case, ERISA's basic purpose requires that its exclusive benefit enforcement mechanism be available for all benefits promised under the plan to all covered individuals. Otherwise, ERISA's mission of fully protecting plan benefit promises, and forbidding conflicting state regulation, would fail.

The court's decision is at odds with numerous other decisions holding that employer participants may pursue remedies for ERISA plan benefits under federal law, and not under state law. Moreover, in subjecting such plans to the added cost and administrative burden of dual regulation, the decision creates confusion and uncertainty for ERISA plan sponsors and administrators. Accordingly, the Court should grant certiorari to avoid a grievous and troublesome interpretation of ERISA that is inconsistent with the decisions of other federal courts.

A. The Court Below Fundamentally Erred in Determining That Sole Proprietors, Partners, and Corporate Owners Cannot Be "Participants" in ERISA Plans When They Are Specifically Covered by Such Plans

The fundamental underpinning of the Sixth Circuit's decision is its conclusion that sole proprietors, partners, and corporate owners cannot be "participants" or "beneficiaries" for purposes of ERISA, because they are not "employees" within the meaning of the relevant ERISA definition. That conclusion rests on a misinterpretation of ERISA's basic provisions and a misunderstanding of their purpose.

As this Court noted in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), ERISA is a "comprehensive and reticulated statute" designed to ensure the fulfillment of benefit promises. *Id.* at 510 (quoting *Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 361 (1980)). It achieves this goal by delineating an exclusive federal mechanism for the enforcement of benefit promises made by ERISA plans. *Id.* at 523; *see* ERISA § 502, 29 U.S.C.§ 1132 (ERISA enforcement provisions).

Unfortunately, the terms used in ERISA to describe the scope of its benefit remedies have caused some confusion in implementation. *Nationwide Mutual Insurance Co. v. Darden*, 112 S. Ct. 1344, 1348 (1992) ("ERISA's nominal definition of 'employee' . . . is completely circular and explains nothing"). The definition of these terms, therefore, must be informed by their context. If Congress intended ERISA to provide an *exclusive* mechanism to enforce benefit promises, it must also have intended that federal mechanism to apply to all individuals who are entitled to plan benefits. Thus, as the Department of Labor has stated,[3] the provisions of ERISA, including those at issue in this case, must be interpreted "liberally" in accordance with "the protective purposes of ERISA." Department of Labor, Advisory Opinion No. 77-75A (Sept. 21, 1977) (available on LEXIS, 1977 ERISA LEXIS 14).

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[3] The Department of Labor is the federal agency given authority by Congress to interpret and enforce Title I of ERISA. *See* ERISA § 505, 29 U.S.C. § 1135 (authority to promulgate appropriate regulations); ERISA § 502, 29 U.S.C. § 1132 (enforcement authority).

In accordance with this intent, the terms "participant" and "beneficiary," which define the class of individuals who may sue for ERISA plan benefits, *see* ERISA § 502(a), 29 U.S.C. § 1132(a), must encompass all individuals who are entitled to enforce benefit promises under those plans. *See* Letter from Robert J. Doyle, Director of Regulations and Interpretations, Department of Labor, to Susan Katz Hoffman, at 2 (July 31, 1992) (attached as App. E). This is the only interpretation consistent with ERISA's underlying purposes, as well as its specific provisions.[4]

The court below ignored these controlling ERISA doctrines by narrowly interpreting the terms "participant" and "beneficiary" to exclude employer participants from the same federal remedy that protects their employees covered under the same ERISA plan. Moreover, the court compounded its error by allowing such employers to sue for benefits under state law, directly contravening this Court's admonition that regulation of employee benefit plans is "exclusively a federal concern." *Alessi*, 451 U.S. at 523.

In reaching its conclusion, the court relied on a Department of Labor regulation, which states in full:

Employees. For purposes of this section:

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[4] *See, e.g.*, ERISA § 403(b)(3)(A), 29 U.S.C. § 1103(b)(3)(A) (exempting certain custodial accounts from ERISA's trust requirement when "some or all of the *participants* are [self-employed individuals]") (emphasis added); ERISA § 4001(b), 29 U.S.C. § 1301(b) (sole proprietors and partners treated as being employed by themselves); ERISA § 4022(b)(5), 29 U.S.C. § 1322(b)(5) (limiting, but not excluding, the coverage of "substantial owners" participating in plans maintained by unincorporated trades or businesses under the benefit guarantee program of ERISA Title IV).

> (1) An individual and his or her spouse shall not be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse, and
>
> (2) A partner in a partnership and his or her spouse shall not be deemed to be employees with respect to the partnership.

29 C.F.R. § 2510.3-3(c). In quoting this regulation, however, the court omitted any reference to its crucial introductory words: "For purposes of *this section* . . . ." 29 C.F.R. § 2510.3-3(c) (emphasis added). A preceding subsection of the regulation clarifies exactly what these "purposes" are:

> *This section* clarifies the definition in *section 3(3)* [of ERISA] of the term "employee benefit plan" for purposes of Title I of [ERISA] and this chapter.

29 C.F.R. § 2510.3-3(a) (emphasis added).

A limiting definition of "employee" for the purposes of section 3(3) was necessary because of the ERISA requirement that a plan covering *no* employees is not an "employee benefit plan," and therefore is not within the scope of ERISA. 29 C.F.R. § 2510.3-3(b). However, while the regulation is clearly relevant to the definition of "employee benefit plan" in *section 3(3)* of ERISA,[5] it just as clearly does not define "employee" for other purposes, including the mean-

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[5] This threshold issue had already been resolved by the court in favor of ERISA coverage, since the plan did cover common law employees as well as their employer. *See supra* pp. 4-5.

ings of "participant" and "beneficiary" in *sections 3(7) and 3(8)*. But these are precisely the sections to which the court below erroneously applied the regulation.

The error of the court's rationale is most clearly exposed by the preamble accompanying the original promulgation of 29 C.F.R. § 2510.3-3. That preamble makes clear that the word "employee," as it appears in the definition of "participant" in section 3(7), must be interpreted much more broadly than the section 3(3) definition erroneously applied by the Sixth Circuit. In the first proposed version of the Department's regulation, the narrow definition of "employee" quoted above had been applied to all of Title I of ERISA, including sections 3(7) and 3(8) and other provisions defining the scope of ERISA benefit remedies. 40 Fed. Reg. 24,642, 24,643 (June 9, 1975) (proposed 29 C.F.R. § 2510.3-6).

Certain commenters objected to this narrow definition of "employee" because of its effect on the definition of "participant" in section 3(7) of ERISA. 40 Fed. Reg. 34,526, 34,528 (Aug. 15, 1975). These commenters noted that ERISA imposes fiduciary duties requiring, among other things, that all plans be operated "for the exclusive purpose of . . . providing benefits to participants and their beneficiaries." ERISA § 404(a)(1)(A), 29 U.S.C. § 1104(a)(1)(A). Thus, if employers were not "participants" under section 3(7), breaches of fiduciary duty would be committed every time an ERISA plan paid benefits to an employer. 40 Fed. Reg. at 34,528. Such violations would arise whether the benefits were paid under state or federal law, because in either event the assets of an ERISA plan would be used to pay benefits to individuals who

are not "participants" or "beneficiaries" under the unduly restrictive interpretation of those terms. To avoid this obviously unacceptable result, and the extension of a restrictive definition of "participant" to all of Title I, the Department declared that "the definition of 'employee' formerly appearing in proposed § 2510.3-6 has been inserted into § 2510.3-3 [its current location] *and restricted in scope to that section.*" *Id.* (emphasis added).[6]

By extending the restrictive concept of "employee" in section 2510.3-3 to determine the definition of "participant" in ERISA § 3(7), the court committed precisely the error the Department of Labor sought to prevent. As a result, it created the very same intolerable consequences described in the regulatory preamble. Accordingly, this Court should grant certiorari to correct the Sixth Circuit's fundamental error and its unintended and unfortunate consequences, described *infra*.[7]

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[6] The court also supported its broad reading of 29 C.F.R. § 2510.3-3(c) by concluding that the exclusion of employers was necessary to fulfill the "fundamental requirement of ERISA . . . that 'the assets of the plan shall never inure to the benefit of any employer.' " App A at 12a (quoting ERISA § 403(c)(1), 29 U.S.C. § 1103(c)(1)). Citation of this provision, however, begs the question whether sole proprietors, partners, and corporate owners, acting in their capacity as plan participants, violate the anti-inurement requirement when they enroll in, pay for, and receive benefits under the terms of an ERISA plan. Moreover, the solution reached by the Sixth Circuit does nothing to rectify any perceived problem in this regard: If the successful pursuit of a claim for benefits from an ERISA plan creates inurement to the benefit of an employer, that problem arises whether the claim is pursued under ERISA or under state law.

[7] *Nationwide Mutual Insurance Co. v. Darden*, 112 S. Ct. 1344

B. The Decision Below Is at Odds With Prior Decisions of This Court and of Other Circuit Courts of Appeal

The Sixth Circuit's erroneous decision conflicts with the ERISA opinions of numerous other courts. In several parallel contexts, these other courts have allowed sole proprietors, partners, and corporate owners to pursue ERISA remedies for benefits owed to them under ERISA plans.

In *Forbau v. Aetna Life Insurance Co.*, No. D-1235 (Tex. Nov. 4, 1992) (available on WESTLAW, 1992 WL 316493 (Tex.)), for example, the Texas Supreme Court expressly found that the dependent of a corporate owner was authorized as "a plan participant or beneficiary to bring an action 'to recover benefits due to [her] under the terms of the plan . . . .' " *Forbau*, slip op., at 3 (quoting ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B)). Like the court below, the Texas court noted that the employer's partial payment of premiums on behalf of his employees brought the plan within the ambit of ERISA. *Id.*, slip op., at 2. For the Texas court, however, this determination definitively resolved the issue. Because the plan was governed by ERISA, all claims on behalf of the employer's dependent related to the plan and therefore had to be asserted under ERISA; state law was preempted. *Id.* at 2-3.

(1992), is not to the contrary. In that case, the Court adopted "the general common law of agency" to determine whether an insurance agent covered by an ERISA plan was an "employee," *id.* at 1348 (quoting *Community for Creative Non-Violence v. Reid*, 490 U.S. 730, 751-52 (1989)), only because it was provided with no regulatory guidance to the contrary and no consequences antithetical to ERISA. *Id.* at 1348, 1349 n.5. Both of these factors demand a different result in this case. *See supra* pp. 7-12.

Similarly, the Ninth Circuit, in *Harper v. American Chambers Life Insurance Co.*, 898 F.2d 1432 (9th Cir. 1990), upheld the right of a partner's dependent to pursue benefit remedies under ERISA. The court had no doubt as to the sweeping preemptive effect of ERISA on all state law benefit remedies, including those pursued by partners:

> If [the plan is] an ERISA plan, then only ERISA remedies are potentially available, for ERISA "supercede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."

Id. at 1433.[8] Thus, while the Ninth Circuit found that the partner could not be a "participant" because he was not an "employee" under ERISA § 3(6), 29 U.S.C. § 1002(6), it found that both the partner and his wife were "beneficiaries" because they were persons designated "by a participant, *or by the terms of an employee benefit plan*, who [are] or may become

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[8] This reading finds further support in the Ninth Circuit's subsequent decision in *Kennedy v. Allied Mutual Insurance Co.*, 952 F.2d 262 (9th Cir. 1991), which involved the benefit claims of two corporate owners under a plan that, according to the plaintiffs, also covered non-owner employees. The Ninth Circuit stated:

> The central question of this case in its current status is whether the Plan and the Bond are governed by ERISA. If not governed by ERISA, as concluded by the district court . . . then California law controls.

Id.; *see also id.* at 264 n.2 ("Both parties agree that if the Plan was established and maintained in compliance with ERISA, ERISA law controls this dispute. Conversely, if the Plan does *not* comply with ERISA, California law controls.") (emphasis by the court).

entitled to a benefit thereunder." ERISA § 3(8), 29 U.S.C. § 1002(8) (emphasis added) (quoted in *Harper*, 898 F.2d at 1434). In this way, the court preserved ERISA's exclusive federal regulation of employee benefits, and avoided the unacceptable result of "deprivf ing] [employers] of legal recourse for their claims." *Id.* at 1433.[9]

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[9] On the other hand, at least three circuit courts, in addition to the court below, have held that employers are not "participants" entitled to maintain actions under ERISA to recover plan benefits. *Kwatcher v. Massachusetts Service Employees Pension Fund*, 879 F.2d 957, 964 (1st Cir. 1989); *Giardono v. Jones*, 867 F.2d 409, 412 (7th Cir. 1989); *Peckham v. Board of Trustees*, 653 F.2d 424, 427-28 (10th Cir. 1981). All of these decisions, however, involved so-called "Taft-Hartley plans" jointly administered by union and management trustees. *See Kwatcher*, 879 F.2d at 958 n.2; *Giardono*, 867 F.2d at 411; *Peckham*, 653 F.2d at 425. Such plans are subject to independent requirements under section 302 of the Labor Management Relations Act ("LMRA"), 29 U.S.C. § 186, which have been interpreted to bar the participation of employers in such plans. *See Aitken v. IP & GCU-Employer Retirement Fund*, 604 F.2d 1261, 1265 (9th Cir. 1979) (citing cases). Although the courts in *Kwatcher*, *Giardono*, and *Peckham* relied in large part on an ERISA-based rationale similar to that of the court below, thus establishing a circuit split that extends beyond the Sixth Circuit, the results in these cases could be sustained through application of the independent requirements of the LMRA, which are not at issue in this case.

At the district court level, at least one court has held, outside the Taft-Hartley plan context, that partners in a law firm are not "participants" or "beneficiaries" entitled to pursue a benefit remedy under ERISA, although that court did not decide whether the partners could pursue a parallel remedy under state law. *Pitre v. Louisiana Health Service & Indemnity Co.*, 122 F.R.D. 497 (W.D. La. 1988).

Numerous other decisions provide further support for a strict dichotomy between ERISA and non-ERISA plans. With respect to the former, all benefit remedies (including those of employers) are governed by ERISA. *See, e.g., Williams v. Wright*, 927 F.2d 1540 (11th Cir. 1991) (benefit plans with only one employee participant, and involving ERISA-covered benefits, were ERISA plans, and state law actions seeking plan benefits were therefore preempted by ERISA). With respect to non-ERISA plans, on the other hand, state law benefit claims may be pursued. ERISA § 514(a), 29 U.S.C. § 1144(a) (preemption applies only to laws that relate to employee benefit plans governed by ERISA); *see, e.g., Schwartz v. Gordon*, 761 F.2d 864 (2d Cir. 1985) (ERISA remedies not available for Keogh plan falling outside of ERISA's "employee benefit plan" definition).

The court below ignored the principles established by these decisions. The court had no trouble concluding that the plan met the definition of an ERISA-covered employee welfare benefit plan. App. A at 7a-9a. However, the court disregarded the logical consequence of finding an ERISA plan, and instead invented a new doctrine incompatible with the holdings of these other courts. It held that an ERISA plan covering both employers and their employees results in preemption of employees', but not their employers', state law benefit remedies:

> In order for an individual to bring an action to recover benefits owed under an ERISA plan, the individual must be a "participant" or beneficiary of the plan; if the plaintiff is not a "participant" or "beneficiary," he may sue under and seek the broader relief pro-

> vided by state tort law. However, ERISA regulation applied to the employees . . . who participate in the group health insurance coverage.

Id. at 13a (citation omitted).[10] In reaching this conclusion, the court ignored the circuit court decisions above, and relied instead on dictum from a single district court decision. *See Dodd v. John Hancock Mutual Life Insurance Co.*, 688 F. Supp. 564, 568 (E.D. Cal. 1988) (cited in App. A at 13a).[11]

Thus, the Sixth Circuit's decision, which allows employers to pursue actions for ERISA plan benefits

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[10] The obvious flaw in the court's reasoning is that it asks the wrong question: whether the plaintiffs have a certain *remedy* under ERISA, rather than whether the remedy that is sought "*relate*[*s*] *to*" an ERISA plan. As this Court noted in *Pilot Life*, Congress made careful "policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme" established in ERISA. *Pilot Life*, 481 U.S. at 54. Any preemption inquiry that would allow state law remedies to proceed based solely on the absence of parallel remedies under ERISA, regardless of whether such remedies "relate to" employee benefit plans, would upset the policy choices that Congress made. Of course, a proper understanding of ERISA would allow a remedy in this case, since employers would be "participants" entitled to seek benefits under ERISA. *See supra* pp. 7-12.

[11] The passage from *Dodd* cited by the Sixth Circuit was part of a preliminary framing of the issues in that case, and rested upon no authority. Moreover, the court in *Dodd* ultimately avoided any issue as to the availability of a state law action by correctly holding that "employers" under ERISA—at least employers who gained that status as corporate owners—can be "participants" as employees of the corporation, thereby allowing maintenance of a benefit action under ERISA. *Dodd*, 688 F. Supp. at 571.

under state law rather than as "participants" or "beneficiaries" under ERISA, conflicts with established principles recognized in ERISA case law. The inconsistency created by this decision in implementing an important federal law provides ample grounds upon which to accept review of this case.

C. The Sixth Circuit's Decision Contravenes Clearly Expressed Congressional Intent, Creating Disruption, Confusion, and Unnecessary Expense in the Implementation of ERISA

The decision below is worthy of certiorari not only because it misconstrues Department of Labor regulations and conflicts with other circuit law, but also because of its inconsistency with the clear congressional intent underlying ERISA preemption and its far-reaching impact.

In passing ERISA, Congress expressly found that "the operational scope and economic impact of [employee benefit] plans is increasingly interstate." ERISA § 2(a), 29 U.S.C. § 1001(a). Thus, it was imperative that the uniform federal standards of ERISA become the exclusive law governing employee benefit plans, in order to "eliminat[e] the threat of conflicting and inconsistent State and local regulation." 120 Cong. Rec. 29,197 (1974) (statement of Rep. Dent) (quoted in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 (1983)); 120 Cong. Rec. 29,933 (1974) (statement of Sen. Williams) (quoted in *Shaw*, 463 U.S. at 99).

This complete displacement of state regulation was so important that one congressman labeled it the "crowning achievement" of ERISA. 120 Cong. Rec. 29,197 (1974) (statement of Rep. Dent) (quoted in

Shaw, 463 U.S. at 99). Moreover, in no less than ten cases over the past decade, this Court has clarified the broad range of ERISA preemption and emphasized its paramount importance.[12] Thus, with "very limited exceptions," *Shaw*, 463 U.S. at 104, none of which apply in this case,[13] ERISA broadly preempts "any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan [governed by ERISA]." ERISA § 514(a), 29 U.S.C. § 1144(a) (emphasis added).[14]

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[12] *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985); *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987); *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988); *Massachusetts v. Morash*, 490 U.S. 107 (1989); *FMC Corp. v. Holliday*, 111 S. Ct. 403 (1990); *Ingersoll-Rand Co. v. McClendon*, 111 S. Ct. 478 (1990). The Court heard argument in yet another ERISA preemption case earlier this month. *District of Columbia v. Greater Washington Board of Trade*, No. 91-1326 (U.S. argued Nov. 3, 1992).

[13] ERISA saves from preemption all state laws regulating insurance, ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), so long as the state law does not deem an employee benefit plan to be insurance for purposes of state regulation, ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B). However, the Court's decision in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), concluding that state law actions alleging bad faith in processing claims under employee benefit plans are not insurance laws for purposes of this preemption exception, disposes of any contention that the bad faith claims in this case are saved from preemption by the insurance savings clause.

[14] This Court has repeatedly emphasized the sweeping scope of the words "relate to" in ERISA's preemption provision. *E.g.*, *Shaw*, 463 U.S. at 96 ("The breadth of § 514(a)'s reach is ap-

It is impossible to imagine a state law more clearly "relate[d] to" ERISA-governed employee benefit plans than a law governing the processing of plan benefit claims by individuals actually participating in and receiving benefits from an ERISA plan. For example, in *Pilot Life*, this Court had no difficulty finding preemption with respect to claims arising from benefit decisions by a health insurance plan essentially identical to the state law claim in this case, stating:

> The common law causes of action raised in [the plaintiff's] complaint, each based on alleged improper processing of a claim for benefits under an employee benefit plan, undoubtedly meet the criteria for preemption under § 514(a).

Pilot Life, 481 U.S. at 48; *see also Alessi*, 451 U.S. at 510 (noting the centrality of benefit matters to ERISA's regulatory purpose and preemptive effect).

The decision below strikes at the very heart of these important principles. Under the doctrine prevailing in other circuits, the conduct of sponsors and administrators of ERISA-covered employee benefit

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parent from that section's language"); *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 739 (1985) (describing the "broad scope of [ERISA's] preemption clause" derived from the "broad common-sense meaning" of the phrase "relate to"); *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 46 (1987) ("[T]he express preemption provisions of ERISA are deliberately expansive."); *FMC Corp. v. Holliday*, 111 S. Ct. 403, 407 (1990) ("The preemption clause is conspicuous for its breadth."); *see also Morales v. TransWorld Airlines, Inc.*, 111 S. Ct. 2031, 2037 (1992) (noting, in a different context, that the "ordinary meaning" of the phrase "relate to" is quite broad, and thus "express[es] a broad preemptive purpose").

plans is governed by ERISA standards. In the Sixth Circuit, however, ERISA-covered employee benefit plans covering both employers and employees will no longer have the benefit of ERISA's "exclusive federal regulation," but rather will be subject to simultaneous regulation under state law.[15]

Indeed, the Sixth Circuit's decision compounds the difficulties that prompted Congress to pass ERISA. While Congress found the existence of "conflicting and inconsistent" state laws to be unacceptable, the holding below assures that benefit plans will be subject not only to ERISA standards, but also to all state laws. Thus, plan administrators in the Sixth Circuit will be caught between potentially conflicting interpretations of identical plan terms depending on whether employers (and state law standards) or employees (and ERISA standards) are at issue. Such a conundrum places administrators in the untenable position of having to vary plan interpretations depending on the identity of the claimant, creating a failure of "uniform construction" that itself may violate ERISA's fiduciary standards. *See, e.g., Wildbur v. Arco Chemical Co.*, 974 F.2d 631, 638 (5th Cir. 1992).[16]

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[15] Such duplicative regulation raises the same concern, expressed in another context in *Darden*, about "the capacity of companies . . . to figure out who their employees are and what, by extension, their pension fund obligations will be." *Darden*, 112 S. Ct. at 1350. This concern applies with special force to the practical need of plan administrators, insurance providers, and self-insured employers to know whether state law claims are cognizable for employer-participants.

[16] Thus, the decision below "could apparently lead to different results for claimants . . . enrolled in identical plans," creating precisely the result this Court found unacceptable in *Darden*.

Nor are the intolerable practical problems of the Sixth Circuit's decision limited to a small number of plans. In fact, the practice of including sole proprietors, partners, or corporate owners in the same plan with employees is commonplace, particularly when the pool of participants is relatively small. According to a recent survey, 69 percent of employees at "small establishments" (those with less than 100 employees) had employer-provided medical coverage; 64 percent had employer-provided life insurance; and 42 percent had an employer-provided retirement plan. U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Small Private Establishments, 1990*, at 1 (1991). Given the size of these enterprises, it is likely that a large portion of these benefits are provided through plans that include both employer and employee participants. Even for larger concerns, where such employer-provided coverage is even more widespread, *see id.* (92 percent receiving health coverage, 94 percent receiving life insurance, and 81 percent participating in a retirement plan), it is not unreasonable to expect a significant number of mixed employer-employee plans.

The practice of encompassing employers and employees in a single plan is encouraged by the structure of group insurance rates and other economies of scale, which make it desirable that health plans and other employee benefit plans cover as many individuals as possible. Few enterprises—particularly small businesses—would find it economical to maintain separate

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112 S. Ct. at 1350. Indeed, the possibility of differing results from the opinion below is far greater than in *Darden*, because the Sixth Circuit's opinion applies two divergent standards rather than one standard that is arguably vague.

health insurance plans for their owners and for other employees. Rather, as in this case, both administrative convenience and economics dictate coverage by a single plan.

While the problems created by the Sixth Circuit's opinion could be avoided, at least prospectively, if all employers separated entirely their own benefit coverage from that of their employees, such a result is squarely inconsistent with the concepts underlying ERISA and would be neither desirable nor practical. This bifurcation of coverage would increase employer costs enormously, since it not only would destroy the benefits of group coverage for business owners but also would double each employer's administrative burden. These vast cost increases, added to current benefit costs that employers already find nearly intolerable, *see* U.S. Small Business Administration, Office of the Chief Counsel for Advocacy, *Focus on the Future: Small Business in the 1990s*, at 27 (1990) (noting the current inability of many small employers to afford health coverage for their employees), would create strong incentives for employers to withdraw health coverage for their employees.

Thus, if the Sixth Circuit's decision is allowed to stand, and particularly if it is followed in other judicial circuits, it will have a widespread impact that will eviscerate the important preemption provisions enacted by Congress and repeatedly sustained by this Court. Accordingly, the importance and scope of the issues at stake, as well as the confusion and inconsistency created by the split between the decision below and jurisprudence in other circuits, demand review by this Court.

CONCLUSION

For the foregoing reasons, the petition should be granted and this case set for plenary consideration.

November 23, 1992

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APPENDIX

APPENDIX A
UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 91-3652

Richard FUGARINO, Jo Marie Fugarino and Marc A. Fugarino,

Plaintiffs-Appellants,

v.

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY and Consolidated Group, Inc.,

Defendants-Appellees.

Argued June 9, 1992.
Decided July 8, 1992.

Rehearing and Rehearing En Banc
Denied Aug. 24, 1992.

Walter R. Lawrence (argued and briefed), Tallmadge, Ohio, for plaintiffs-appellants.

Lisa M. Newmark, Eliott R. Good (briefed), Philip F. Brown (argued), Chorpenning, Good & Mancuso, Columbus, Ohio, for defendant-appellee.

Before: MARTIN and MILBURN, Circuit Judges; and BROWN, Senior Circuit Judge.

MILBURN, Circuit Judge.

Plaintiffs Richard Fugarino, Jo Marie Fugarino, and Marc A. Fugarino appeal the district court's dismissal of their complaint, which asserted various state law causes

of action relating to an insurance policy purchased from defendant Hartford Life and Accident Insurance Company. The dismissal was under Federal Rule of Civil Procedure 12(b)(6) and based on the ground of preemption pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, et seq. On appeal, the principal issues presented are: (1) whether the insurance plan in question is an employee welfare benefit plan as defined by ERISA, (2) whether the status of plaintiff Richard Fugarino as a self-employed sole proprietor affects the status of the insurance plan pursuant to ERISA, (3) whether the district court erred in dismissing the complaint pursuant to Rule 12(b)(6), and (4) whether the district court's Rule 12(b)(6) dismissal is a grant of summary judgment pursuant to Federal Rule of Civil Procedure 52 because the court considered matters outside the pleadings when deciding the motion for dismissal. For the reasons that follow, we affirm in part, reverse in part, and remand.

I.

A.

This case involves a dispute between the plaintiffs and defendants concerning an insurance policy. The policy is a Group Health Insurance Policy which, as stated, was purchased by plaintiff Richard Fugarino from defendant Hartford Life and Accident Insurance Company. The policy is administered by defendant Consolidated Group Inc.

Plaintiff Richard Fugarino purchased the policy to provide health and medical coverage for himself, his dependents, and for a few of his employees and their dependents. Plaintiff Richard Fugarino is the sole proprietor and operator of a business known as "The Glens Restaurant." Full-time and part-time employees work at the restaurant.

The insurance policy was purchased in November of 1985. Since the policy was purchased, three of Richard Fugarino's restaurant employees have been covered under

the policy. Richard Fugarino advised his employees of the insurance program, and they then decided whether or not they wanted to participate in the coverage. The employees who participated in the coverage paid their own premiums by reimbursing Fugarino. However, Fugarino paid for the coverage of one of his employees, and he paid for coverage for his dependents, plaintiff Jo Marie Fugarino, his wife, and plaintiff Marc A. Fugarino, his minor son. The insurance contract was cancelled in June 1989.

On or about February 1, 1988, plaintiff Marc A. Fugarino was involved in an automobile accident. Marc A. Fugarino, who was 17 years of age at the time of the accident, sustained severe injuries which left him a paraplegic. Plaintiffs submitted a claim to defendants for payment of Marc A. Fugarino's expenses arising out of the automobile accident; however, a dispute arose between the parties concerning payment of the expenses.

B.

On February 10, 1989, plaintiffs brought an action against defendants in the Court of Common Pleas of Summit County, Ohio. Plaintiffs' complaint contained four separate counts. Count One sought judgment against defendants for the amount of Marc A. Fugarino's unpaid medical bills arising out of the automobile accident. Count Two sought judgment for unpaid medical bills incurred by some of plaintiff Richard Fugarino's employees. Counts One and Two were subsequently dismissed by agreement of the parties on November 2, 1989, after a settlement was reached by the parties and as well by the plaintiffs in behalf of the restaurant employees.[1]

[1] At oral argument, counsel for the defendants conceded that the settlement did not cover future medical expenses incurred in behalf of Marc A. Fugarino as a result of his automobile accident on February 1, 1988.

Count Three of the complaint sought compensatory and punitive damages for alleged bad faith by defendants in their handling of the claims submitted by plaintiffs on their own behalf and on behalf of the restaurant employees. Count Four sought a declaratory judgment that the insurance contract was in full force and effect and that defendants were responsible for payment of all past and future medical bills incurred by plaintiffs which were covered under defendant Hartford's insurance policy.

On March 20, 1989, defendants removed plaintiffs' case to the United States District Court for the Northern District of Ohio pursuant to 28 U.S.C. §§ 1441 and 1446. Thereafter, on April 27, 1989, defendants filed a motion to dismiss the complaint on the ground that plaintiffs' claims arose under Ohio law and, thus, were preempted by ERISA. Defendants further asserted that plaintiffs failed to abide by the administrative remedies provided by ERISA and the insurance policy in question and, therefore, that the action was filed prematurely.

Plaintiffs filed a motion in opposition to defendants' motion to dismiss. In their motion, plaintiffs requested that the case be remanded back to state court pursuant to 28 U.S.C. § 1447(c). On June 4, 1991, the district court dismissed plaintiffs' complaint pursuant to Rule 12(b)(6) for failure to state a claim upon which relief can be granted. This timely appeal followed.

II.

A.

Plaintiffs first challenge the dismissal of their complaint pursuant to Federal Rule of Civil Procedure 12(b)(6). They argue that because the district court considered matters beyond the pleadings in granting the dismissal that the dismissal is in effect a grant of summary judgment under Federal Rule of Civil Procedure 56. Second, plaintiffs also argue that the district court erred when it failed to give

them ten days notice of its intent to grant summary judgment in favor of defendants.

From the record, it appears that the district court did consider matters outside the pleadings in dismissing this case. When matters outside the pleadings are presented to and considered by the court in a Rule 12(b)(6) motion, the motion is treated as a motion for summary judgment. *See Friedman v. United States,* 927 F.2d 259, 261 (6th Cir.1991). When matters outside the pleadings are considered in ruling on a Rule 12(b)(6) motion, the parties must be given a reasonable opportunity to present all material made pertinent to the motion under Rule 56. *Id.*

Plaintiffs essentially argue that because they were not given explicit notice that the district court would rely on matters outside the pleadings, they were not given a reasonable opportunity to respond to such matters. However, the record belies such assertion. In this case, plaintiffs had ample opportunity to respond to defendants' evidence.

Defendants filed their motion to dismiss on April 27, 1989. They filed an additional memorandum with exhibits in September 1989 and an additional supplemental memorandum with exhibits in November 1989. The district court did not act on defendants' motion until June 4, 1991, when it dismissed the case. Thus, although plaintiffs did not receive explicit notice that the district court would consider matters outside the pleadings, they had approximately two years to respond to defendants' evidence.

In *Dayco Corp. v. Goodyear Tire & Rubber Co.,* 523 F.2d 389 (6th Cir.1975), we addressed circumstances comparable to the facts in this case. In *Dayco,* the district court granted summary judgment in favor of the defendant. The plaintiff appealed, arguing that the district court should have given the parties ten days notice before he considered the defendant's Rule 12(b)(6) motion as a motion for summary judgment. The plaintiff argued that it did not have ample time to supplement the record. *Id.* at

392. However, the record revealed that seven weeks elapsed between the service of the Rule 12(b)(6) motion and the entry of judgment. We held that although it would have been a better practice for the district court to give notice of its intention to treat a Rule 12(b)(6) motion as a summary judgment motion, no error was committed under the circumstances present in *Dayco. Id.*

In this case, plaintiffs responded to each of defendants' motions or memoranda. Furthermore, given the amount of time which elapsed between the filing of defendants' Rule 12(b)(6) motion and the dismissal of plaintiffs' case, it can hardly be said that plaintiffs did not have a reasonable time to respond to defendants' evidence. Thus, the district court did not commit error in failing to give notice to the parties that it would consider matters outside the pleadings in dismissing this case.

B.

As noted above, the district court's dismissal of this case is properly treated as a grant of summary judgment in favor of defendants. This court reviews a district court's grant of summary judgment de novo. *See Faughender v. City of North Olmsted, Ohio,* 927 F.2d 909, 911 (6th Cir. 1991). Summary judgment is proper pursuant to Federal Rule of Civil Procedure 56(c) if the record shows that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law. *See Canderm Pharmacal, Ltd. v. Elder Pharmaceuticals, Inc.,* 862 F.2d 597, 601 (6th Cir.1988).

C.

Plaintiffs argue that the district court erred in concluding that the group insurance policy purchased by the plaintiff Richard Fuguarino constituted an ERISA plan. ERISA applies to an employee benefits plan if it is established or maintained by an employer or an employee or-

ganization engaged in commerce or in any industry or activity affecting commerce. 29 U.S.C. § 1003(a); *Memorial Hosp. System v. Northbrook Life Ins. Co.*, 904 F.2d 236, 240 (5th Cir.1990).

Plaintiffs initially argue that ERISA cannot apply in this case because the restaurant operated by Richard Fugarino is not an industry or activity affecting commerce. However, plaintiffs' assertion was effectively answered by the Supreme Court in *Katzenbach v. McClung*, 379 U.S. 294, 85 S.Ct. 377, 13 L.Ed.2d 290 (1964). In *Katzenbach*, the Supreme Court held that although a single, family-owned restaurant located in Birmingham, Alabama, had a trivial relation to interstate commerce, that was not enough to remove it from federal regulation. *Id.*, 379 U.S. at 300-01, 85 S.Ct. at 382. Similarly, in this case, the restaurant may have a trivial or limited connection or impact upon commerce, but that is not enough to exempt it from regulation under ERISA.

D.

Plaintiffs next argue that the mere purchase of the group health insurance policy by plaintiff Richard Fugarino was insufficient to establish an ERISA plan. Title I of ERISA applies to "any employee benefit plan." 29 U.S.C. § 1003(a). An employee benefit plan is defined as "an employee welfare benefit plan or an employee pension benefit plan or a plan which is both . . . ." 29 U.S.C. § 1002(3). ERISA describes an "employee welfare benefit plan" as

> any plan, fund, or program . . . established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or

> benefits, or benefits in the event of sickness, accident, disability, death or unemployment. . . .

29 U.S.C. § 1002(1). Thus, by its express terms, ERISA encompasses welfare plans provided through the purchase of insurance. *See Memorial Hosp.*, 904 F.2d at 240. Moreover, it is a common practice for employers to provide health care benefits to their employees through the purchase of a group health insurance policy from a commercial insurance company. *Id.* (citing *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 727, 105 S.Ct. 2380, 2383, 85 L.Ed.2d 728 (1985)).

However, the United States Department of Labor, pursuant to authority granted to it by Congress, has promulgated regulations providing that certain insurance and other benefit plans are excluded from ERISA's coverage. The Department of Labor regulations provide that the term "employee welfare benefit plan"

> shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which
>
> (1) No contributions are made by an employer or employee organization;
>
> (2) Participation in the program is completely voluntary for employees or members;
>
> (3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and
>
> (4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection the program, other than reasonable compensation, excluding any profit, for administrative ser-

> vices actually rendered in connection with payroll deductions or dues checkoffs.

29 C.F.R. § 2510.3-1(j) (1987). Group health insurance plans which meet each of these criteria are excluded from ERISA coverage. *See Hansen v. Continental Ins. Co.*, 940 F.2d 971, 977 (5th Cir.1991). Moreover, the bare purchase of insurance, without any of the above elements present, does not constitute an ERISA plan, although it may be evidence of the existence of an ERISA plan. *See Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489, 492 (9th Cir.1988) (per curiam), *cert. denied*, 492 U.S. 906, 109 S.Ct. 3216, 106 L.Ed.2d 566 (1989) (citing *Donovan v. Dillingham*, 688 F.2d 1367, 1375 (11th Cir. 1982) (en banc)). An employer has not established an ERISA plan if he merely advertises a group insurance plan that has none of the attributes described in 29 C.F.R. § 2510.3-1(j). *Kanne*, 867 F.2d at 492.

In this case, the Department of Labor regulations do not exclude plaintiffs from ERISA's coverage. Fugarino has done far more than purchase a group health insurance policy and advise his employees of its availability. Fugarino pays the premiums for his employees and permits them to reimburse him. Moreover, the record shows that Fugarino pays the health insurance premium for at least one of his employees.

E.

Relying on the case of *Taggart Corp. v. Life and Health Benefits Admin., Inc.*, 617 F.2d 1208 (5th Cir.1980), *cert. denied*, 450 U.S. 1030, 101 S.Ct. 1739, 68 L.Ed.2d 225 (1981), plaintiffs argue that the group health insurance policy in this case does not constitute an ERISA plan. *Taggart*, however, dealt with a multiple employers trust ("MET") which provided group insurance to employers too small to qualify for group rates on their own. The MET in *Taggart* pooled the premiums for a group of small em-

ployers and purchased a group policy for the group. The Fifth Circuit in *Taggart* concluded that the MET was not a statutory employer of an employee organization and, thus, was not within the scope of ERISA coverage. *Id.* at 1210. The court also held that ERISA did not apply to the purchased health insurance where the purchasing employer neither directly nor indirectly owns, controls, administers, or assumes responsibility for the policy or its benefits. *Id.* at 1211.

Subsequent to the Fifth Circuit's decision in *Taggart*, the Eleventh Circuit decided *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir.1982), in which it rejected the Fifth Circuit's reasoning in *Taggart*. In *Donovan* the Eleventh Circuit found that there were five prerequisites to an ERISA employee welfare plan:

> (1) a "plan, fund, or program" (2) established or maintained (3) by an employer or by an employee organization, or by both, (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, unemployment or vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services or severance benefits (5) to participants or their beneficiaries.

Donovan, 688 F.2d 1371. In *Donovan*, the Eleventh Circuit stated that the gist of ERISA's definitions of the terms employer, employee organization, participant, and beneficiary is that a plan, fund, or program falls within the ambit of ERISA only if such plan, fund, or program covers ERISA participants because of their employee status in an employment relationship, and an employer or employee organization is the person that establishes or maintains the plan, fund, or program. *Id.*; 29 C.F.R. § 2510.3-3(b), (c).

The *Donovan* court further stated that at minimum a plan, fund, or program under ERISA implies the existence

of intended benefits, intended beneficiaries, a source of financing, and a procedure to apply for and collect benefits. *Donovan,* 688 F.2d at 1372. Moreover, ERISA does not require a formal, written plan. Rather, ERISA reaches any employee benefit plan if it is established or maintained by an employer or an employee organization, or both, who are engaged in any activities or industry affecting commerce. *Id.* To determine if a plan, fund, or program is a reality, a court must determine whether, from the surrounding circumstances, a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits. *Id.* at 1373.

Thus, the Eleventh Circuit stated that it agreed with *Taggart* to the extent that it held that ERISA does not regulate purchases of health insurance where there is no welfare plan. However, the Eleventh Circuit stated that it disagreed with *Taggart* to the extent that the holding in that case implied that an employer or employee organization that only purchases a group health insurance policy or subscribes to a MET to provide health insurance to its employees or members cannot establish or maintain an employee welfare benefit plan through the purchase of such group health insurance. *Id.* at 1375.

Recently, this court has adopted the reasoning of the Eleventh Circuit in *Donovan. See International Resources, Inc. v. New York Life Ins. Co.,* 950 F.2d 294, 297 (6th Cir.1991), *cert. denied,* ___ U.S. ___, 112 S.Ct. 2941, 119 L.Ed.2d 565 (1992). Thus, the mere fact that plaintiff Richard Fugarino purchased group health insurance from a MET does not preclude ERISA coverage. Moreover, applying the remainder of the *Donovan* analysis to this case, an ERISA plan does exist. From the surrounding circumstances of this case, a reasonable person can ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits. Further, it is clear from the record that plaintiff Richard Fugarino, an employer,

has established and maintained a plan, fund, or program for the purpose of providing health benefits to his employees as participants or beneficiaries of the plan. Therefore, ERISA regulation applies to this case.

F.

Finally, plaintiffs argue that because plaintiff Richard Fugarino is the sole proprietor of a business, the group health insurance he purchased cannot be an ERISA plan. Pursuant to Title I of ERISA,

> . . . the term "employee benefit plan" shall not include any plan, fund or program, . . . under which no employees are participants covered under the plan. . . .

29 C.F.R. § 2510.3-3(b) (19890). The regulations further provide that

> . . . [a]n individual and his or her spouse shall not be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse. . . .

29 C.F.R. § 2510.3-3(c)(1) (1988). As a result of these regulations, a plan whose sole beneficiaries are the company's owners cannot qualify as a plan under ERISA. *See Kennedy v. Allied Mut. Ins. Co.*, 952 F.2d 262, 264 (9th Cir.1991). Further, an employer cannot ordinarily be an employee or participant under ERISA. A fundamental requirement of ERISA is that "the assets of a plan shall never inure to the benefit of any employer . . ." 29 U.S.C. § 1103(c)(1). Only "participants" and "beneficiaries" as defined by ERISA have standing to recover benefits under ERISA. 29 U.S.C. § 1132(a)(1). Under ERISA "participant" means

> any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive

> a benefit of any type from an employee benefit plan. . . .

29 U.S.C. § 1002(7). ERISA defines a "beneficiary" as

> a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

29 U.S.C. § 1002(8). An "employee" and "employer" are plainly meant to be separate entities under ERISA. *See Kwatcher v. Mass. Service Emp. Pension Fund,* 879 F.2d 957, 959 (1st Cir.1989). Thus, a sole proprietor or sole shareholder of a business must be considered an employer and not an employee of the business for purposes of ERISA. *See Kwatcher,* 879 F.2d at 959-60; *Giordano v. Jones,* 867 F.2d 409, 411-12 (7th Cir.1989).

Therefore, neither Richard Fugarino nor his spouse, Jo Marie Fugarino, can qualify as participants in an ERISA plan since Richard Fugarino is the sole proprietor of The Glens Restaurant. Moreover, because their son, Marc A. Fugarino, was covered under the policy based upon his status as their dependent and not as an employee of the restaurant, he is also not a participant or beneficiary under the ERISA plan. Since Richard, Jo Marie, and Marc A. Fugarino are not ERISA participants, the group health insurance policy in this case constitutes an insurance contract governed by state law as to the three of them. In order for an individual to bring an action to recover benefits owed under an ERISA plan, the individual must be a "participant" or "beneficiary" of the plan; if the plaintiff is not a "participant" or "beneficiary," he may sue under and seek the broader relief provided by state tort law. *See Dodd v. John Hancock Mut. Life Ins. Co.,* 688 F.Supp. 564, 568 (E.D.Cal.1988). However, ERISA regulation applies to the employees of The Glens Restaurant who participate in the group health insurance coverage.

G.

Under Ohio law, claims for bad faith dealing in insurance are separate causes of action in tort. *See Hoskins v. Aetna Life Ins. Co.*, 6 Ohio St.3d 272, 452 N.E.2d 1315, 1319 (1983). In this case, plaintiffs have asserted two distinct claims for bad faith dealing—one involving claims for medical expenses for Marc A. Fugarino and one involving claims for medical expenses for certain employees of The Glens Restaurant. Moreover, although plaintiffs settled their claims under Counts One and Two of the complaint, except for Marc A. Fugarino's future medical expenses, they have sought both compensatory and punitive damages under their tort claim in Count Three of their complaint. *See, e.g., AmeriTrust Co. Nat. Ass'n v. West American Ins. Co.*, 37 Ohio App.3d 182, 525 N.E.2d 491, 496 (1987). Thus, plaintiffs' tort claims survive.

Since Marc A. Fugarino is not a participant or beneficiary of the ERISA plan, the claim for bad faith dealing concerning his medical expenses is the subject of Ohio law. Therefore, the district court erred in granting summary judgment for defendants on plaintiffs' claims for bad faith and punitive damages with regard to Marc A. Fugarino under Count Three of their complaint and in not granting plaintiffs' motion for remand of their claims to state court.

With regard to the claims of bad faith dealing and punitive damages concerning the medical expenses of the employees of The Glens Restaurant, the employees are participants and beneficiaries of an ERISA plan. State common law tort claims, such as the employees' claims, are the subject of ERISA preemption. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987). Therefore, the district court properly granted summary judgment in favor of defendants on these claims.

Plaintiffs' final claim, set forth in Count Four of their complaint, seeks a declaratory judgment that the insurance contract in issue in this case is in full force and effect

and that defendants were responsible for payment of all past, present, and *future* medical bills incurred by plaintiffs covered under the insurance contract. As earlier stated, the parties entered into a settlement of Counts One and Two of their complaint, which involved claims for non-payment of benefits under the insurance contract, but reserved their claim for Marc A. Fugarino's future medical expenses. Therefore, the district court erred in granting summary judgment for defendants with regard to plaintiffs' claim for declaratory relief. However, the employees' claim for declaratory relief under Count IV of the complaint is moot.

III.

For the reasons stated, the district court's grant of summary judgment is AFFIRMED with regard to the claims of the employees of The Glens Restaurant for compensatory and punitive damages for bad faith dealing and with regard to Count Four of plaintiffs' complaint. The district court's grant of summary judgment involving plaintiffs' claim for declaratory relief as to Marc A. Fugarino's future medical expenses and their claims for compensatory and punitive damages for bad faith dealing with regard to Marc A. Fugarino is REVERSED and REMANDED to the district court with instructions to remand those claims to state court.

APPENDIX B

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 91-3652

RICHARD FUGARINO; JO MARIE FUGARINO; MARC A. FUGARINO,
Plaintiffs-Appellants,

v.

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY; CONSOLIDATED GROUP, INC.,
Defendants-Appellees.

FILED

Aug. 24, 1992

ORDER

BEFORE: MARTIN and MILBURN, Circuit Judges; and BROWN, Senior Circuit Judge.

The court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this court, and no judge of this court having requested a vote on the suggestion for rehearing en banc, the petition for rehearing has been referred to the original hearing panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied.

ENTERED BY ORDER OF THE COURT

/s/ Leonard Green
Leonard Green, Clerk

APPENDIX C

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

CASE NO. 5:89CV0504

RICHARD FUGARINO, et al.,

Plaintiffs,

vs.

HARTFORD LIFE & ACCIDENT INSURANCE COMPANY, et al.,

Defendants.

MEMORANDUM AND ORDER

HON. GEORGE W. WHITE

This matter is before the Court on Plaintiffs' motion to remand this case back to the Court of Summit County, Ohio. Defendants have filed a motion in opposition to remand. In addition Defendants have filed a motion to dismiss this action pursuant to Civil Rules of Procedure Rule 12(b)(6), and Plaintiffs have opposed Defendants' motion.

The facts of the case are as follows:

This case involves a dispute over an insurance policy between the Plaintiffs and the Defendants. The insurance contract in question is a Group Health Insurance Policy purchased by Richard Fugarino from defendant Hartford Company, and administered by defendant Consolidated Comany. The plan number was GRH-022003 under policy number A398265. Each separate cause of action arose as a result of how Defendants have handled certain claims submitted to the companies by Plaintiffs.

The insurance policy was purchased by Richard Fugarino, to provides health and medical coverage for himself,

his dependents, and for a few of his employees and their dependents. Plaintiffs Richard Fugarino owns and operates a restaurant called the Glens, and he owns the restaurant as a sole proprietor. He employs both full time and part time employees in the business. At different times since the purchase of the insurance policy in November of 1985, there have been as many as three of his employees who have been covered under this insurance policy.

Richard Fugarino would advertise the insurance program to his employees, and the employees would then decide whether or not they would like to participate in the coverage. The employees that wished to participate, were responsible for payment of their own premium by reimbursing Plaintiff. Only one employee's coverage was paid for by plaintiff Richard Fugarino, and in addition, Richard Fugarino paid for the coverage of himself and his dependents. In June of 1989, the insurance contract was canceled.

Prior to the cancellation of the insurance policy, in February 1988, Marck Fugarino, Richard Fugarino's minor dependent was in an automobile accident and sustained severe injuries that left him a paraplegic. A claim was submitted by the Plaintiffs for the injuries sustained due to the accident, and a dispute arose between the parties with respect to the payment of the claims.

Plaintiff's complaint contains four counts against the Defendants. Count One and Count Two are claims for payments of benefits under the terms of the policy. The causes of action for payments pursuant to Count One and Count Two have been settled between the parties on October 30, 1989, and because of this fact both counts have been dismissed.

In Count Three of Plaintiffs' complaint alleges that defendants Hartford, and Consolidated had a duty to act in good faith and fair dealing in processing and paying claims of the insured. Plaintiffs contend that the

Defendants breached its duty and did not act in good faith, and it is for this reason that Plaintiffs are seeking punitive damages from the Defendants.

The Fourth Count of Plaintiffs' complaint seeks a declaratory judgment finding the insurance contract at issue to be in full force and effect.

This Court is in agreement with the Defendants when they state there are two issues that must be resolved to determine if this case should be remanded back to state court, and those issues are: (1) whether the insurance plan at issue, the multiple employer trust, was governed by ERISA; and (2) whether Plaintiffs were participants in the plan within the meaning of ERISA.

Plaintiffs place much reliance in *Taggart Corporation, et al. v. Life & Health Benefits Administration Inc., et al.*, 617 F.2d 1208 (5th Cir. 1980), in establishing that they were not participants under ERISA. If Plaintiffs prove they were not participants under ERISA, then this case must be remanded back to state court to resolve the remaining issues.

Since this Court is of a different opinion than the *Taggart* court, this Court shall not go into great detail in developing the facts of that case. This Court will only state that the *Taggart* court was dealing with an ERISA issue that involved an employer's sole employee and the employee's wife. The Court found that the Security Multiple Employers Trust (SMET) was a proprietary enterprise, established and operated by independent businessmen for their personal profit. The Court went on to state:

> As a kind of insurance mutual fund, SMET acts as a mere conduit for hundreds of unrelated subscriber customers, forwarding premium payments to a group insurer. Neither Taggart Corporation nor any other employer participates in SMET's day-to-day operation or administration . . . . Such

> an enterprise is neither established nor maintained by the appropriate parties to confer ERISA jurisdiction . . . .

Taggart Corp. v. Life & Health Benefits Administration, 617 F.2d 1208, at 1210 (5th Cir. 1980).

In the present case the dispute arose over claims filed by Plaintiffs under the "Employee Welfare Benefits Plan (EWBP). Plaintiffs contend they were not participants, and Defendants alleges that Plaintiffs were participants of the plan. Plaintiffs contend they only purchased an insurance policy from the Defendants.

ERISA was enacted by the legislature to protect working men and women from abuses in the administration and investment of private retirement plans and employee welfare plans. See *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724, 732, 105 S.Ct. 2380, 2385, 85 L.Ed.2d 728, 735-736 (1985).

The purpose of ERISA is defined in 29 U.S.C. Section 1002(1) which reads as follows:

> (1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is heretofore established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section

> 186(c) of this title (other than pension retirement or death, and insurance to provide such pensions).

In the present case this Court must determine if the ERISA statutes apply, and if they do apply then this Court will have jurisdiction over this matter, and this case will not be remanded back to state court. If this case does fall under the ERISA statutes then the pre-emptive provision will be pivotal in deciding how this case will be resolved.

The pre-emptive provision of ERISA contains three clauses commonly referred to as the preemptive clause, the saving clause and the deemer clause. The Supreme Court recently described the interrelationship of these provisions as follows:

> If a state law 'relate[s] to . . . employee benefit plan[s]' it is pre-empted. § 514(a). The saving clause excepts from the pre-emption clause laws that 'regulat[e] insurance.' § 514(b)(2)(A). The deemer clause makes clear that a state law that 'purport[s] to regulate insurance' cannot deem an employee benefit plan to be an insurance company. § 514(b)(2)(B).

See *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 1552, 95 L.Ed.2d 39 (1987).

A specific plan or program will be governed by ERISA if the plan or program covers participants because of their employee status in an employment relationship, and an employer or employee organization is the person that establishes the plan or program. See 29 U.S.C. § 1001, *et seq.*

A court must not look at just one aspect or one element in deciding if a plan or program was intended to qualify as coming under the auspicious of ERISA. A court must look at the totality of a situation in making its determination. In *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982), the court asserted the following position:

> In determining whether a plan, fund or program (pursuant to a writing or not) is a reality a court must determine whether from the surrounding circumstances a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits. Some essentials of a plan, fund, or program can be adopted, explicitly or implicitly, from sources outside the plan, fund or program. . . . But no single act in itself necessarily constitutes the establishment of the plan, fund or program. *Id.* at 1373.

The Court is satisfied that Plaintiffs have satisfied the five prerequisites for establishing an ERISA program, and this Court is of the opinion that Plaintiffs were both participants and beneficiaries under ERISA. The five elements are:

> (1) a "plan, fund, or program" (2) established or maintained (3) by an employer or by an employee organization, or by both, (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, unemployment or vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services or severance benefits (5) to participants or their beneficiaries.

Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982).

This Court does not concur with Plaintiffs' position that they were not a part of an ERISA plan or that they did not maintain the plan for the benefit of their employees. The Glens restaurant began participating in the multiple employer trust in November of 1985, and an administration kit was issued to the employer containing forms and information to be used to administer the plan. The Defendants have supplied to this Court a copy of the bro-

chure that was issued to Plaintiffs that contained the indenture of trust, Article II Section 2, which states the following:

> Each participating Employer shall be the Plan Administrator with respect to each insured welfare benefit plan for its participating employee.
>
> A document containing information specifically about ERISA, and recommendations concerning the preparation of a Summary Plan Description and a Summary Annual Report. The participant employer is identified as the Plan Sponsor and Plan Administrator.

There is no question in this Court's mind Plaintiffs knew they were entering into an ERISA plan, and for several years they were participants of the plan.

In the holding of *Taggart Corporation v. Life and Health Benefits Administration, Inc.*, 617 F.2d 1208 (5th Cir. 1980), that court found that the Security Multiple Employer Trust which was providing group insurance to employers too small to qualify for group rates on their own, was not itself an employee welfare benefit plan and that Taggart Corporation's subscription to SMET to furnish insurance coverage to Taggart's sole employee did not constitute a plan, fund or program within the meaning of ERISA.

In *Donovan v. Dillingham*, 688 F.2d 1367 at 1375 (11th Cir. 1982) that court in part disagreed with the *Taggart* decision when that court held the following:

> If Taggart is interpreted to mean ERISA does not regulate purchases of health insurance when there is no welfare plan, we agree. The purchase of insurance is only a method of implementing a plan, fund, or program and is evidence of the existence of a plan but is not itself a plan. If Taggart implies that an employer or employee

> organization that only purchases a group health insurance policy or subscribes to a MET to provide health insurance to its employees or members cannot be said to have established or maintained an employee welfare benefit plan, we disagree. To that extent Taggart shall not longer be binding in the Eleventh Circuit.

This Court is of the same opinion as the *Donovan* court with respect to when an ERISA plan may be said to have been established.

Congress enacted ERISA to protect working men and women from abuses in the administration and investment of private retirement plans and employees welfare plans. ERISA established minimum standards for implementing and carrying out those plans. See *Donovan v. Dillingham*, 688 F.2d 1367 at 1370 (11th Cir. 1982).

In order for an individual to be brought under the umbrella of the ERISA statutes they must be either a participant or a beneficiary of an ERISA plan. If a plaintiff is not a participant or a beneficiary of an ERISA plan, he/she may sue under and seek the broader relief provided by state tort law. *Dodd v. John Hancock Mutual Life Insurance Company*, 688 F.Supp. 564 (E.D. Cal. 1988).

But since this Court has already determined that Plaintiffs were participants under ERISA, this case must come under the jurisdiction of this Court. Furthermore, since the only issues remaining before this Court are not actionable due to the pre-emptive provisions of ERISA, this Court hereby denies Plaintiffs' motion to remand, and dismiss this case pursuant to Civil Rules of Procedure Rule 12(b)(6).

IT IS SO ORDERED.

/s/ George W. White
George W. White 6-4-91
UNITED STATES DISTRICT JUDGE

APPENDIX D

ERISA §§ 3(6)-(8), 29 U.S.C. §§ 1002(6)-(8), provide in full:

> (6) The term "employee" means any individual employed by an employer.
>
> (7) The term "participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.
>
> (8) The term "beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

ERISA § 514(a), 29 U.S.C. § 1144(a), provides in full:

> Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b). This section shall take effect on January 1, 1975.

APPENDIX E

U.S. Department of Labor

Ms. Susan Katz Hoffman
Pepper, Hamilton & Scheetz
3000 Two Logan Square
Eighteenth & Arch Streets
Philadelphia, Pennsylvania 19103-2799

Dear Ms. Hoffman:

This is in reply to your request for an information letter regarding the applicability of title I of the Employee Retirement Income Security Act of 1974 (ERISA). Specifically, you ask whether title I of ERISA applies to group medical programs which provide medical coverage to a sole proprietor or a partner in an unincorporated business, as well as common law employees, and whether the claims made by such a sole proprietor or partner would be subject to the ERISA claims procedure.

Section 4(a) of title I of ERISA generally provides that any employee benefit plan established or maintained by an employer engaged in commerce or in any industry or activity affecting commerce, by any employee organization representing employees engaged in commerce or in any industry or activity affecting commerce, or by both will be covered by that title unless excluded in subparagraph (b). A program providing medical coverage would generally be considered to be providing benefits among those included in the definition of an employee welfare benefit plan.

The definition of the term "employee benefit plan" contained in section 3(3) of title I of ERISA includes both employee welfare benefit plans and employee pension benefit plans. In regulation 29 CFR 2510.3-3, the Department of Labor (the Department) clarified the definition of the term "employee benefit plan" for the purposes of title I of ERISA. Paragraph (b) of § 2510.3-3 provides that "the term 'employee benefit plan' shall not include any plan, fund or program, other than an apprenticeship or other

training program, under which no employees are participants covered under the plan . . ." For purposes of the regulation, paragraph (c) of § 2510.3-3 provides that certain individuals shall not be deemed to be employees. Specifically § 2510.3-3(c) provides that:

> (c) Employees. For purposes of this section:
>
> (1) An individual and his or her spouse shall not be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual and his or her spouse, and
>
> (2) A partner in a partnership and his or her spouse shall not be deemed to employees with respect to the partnership.

If a benefit program were limited to individuals identified in § 2510.3-3(c), the benefit program would not constitute an employee benefit plan described in section 3(3) of title I of ERISA and, therefore, would not be covered by that title. If, on the other hand, the benefit program includes one or more common law employees as well as an individual described in § 2510.3-3(c), such program would be an employee benefit plan within the meaning of section 3(3) of title I of ERISA.

Employee benefit plans covered under title I of ERISA must comply with the claims procedure provisions of section 503 of title I of ERISA and the Department's regulation concerning claims procedures, 29 CFR 2560.503-1. A plan's claims procedure applies to any participant or beneficiary covered under the employee benefit plan, including any participant or beneficiary described in § 2510.3-3(c).

We hope this information will be helpful to you.

Sincerely,

/s/ Robert J. Doyle
ROBERT J. DOYLE
Director of Regulations
and Interpretations